DD-525-PF (6-07)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

INTAKE APPLICATION - 3 YEARS AND OLDER

ASSISTS I.D.

1. APPLICANT'S NAME *(Last, First, M.I.)*	2. DATE OF BIRTH	3. SOC. SEC. NO. *(Voluntary)*

4. DESCRIBE YOUR PRIMARY CONCERN / DISABILITY AND WHEN IT BEGAN

☐ Autism ☐ Cerebral palsy ☐ Cognitive disability ☐ Epilepsy ☐ Developmental delay

5. MARITAL STATUS	6. SEX	7. TOTAL NO. IN HOUSEHOLD
☐ Never Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Married	☐ Male ☐ Female	

8. ETHNICITY

☐ White ☐ Black ☐ Hispanic ☐ Other: ☐ Native American *(Tribe)*: ☐ Living on reservation

9. CURRENT SCHOOL/DISTRICT *(If applicant is under 22 years of age)*

10. REFERRAL SOURCE, ADDRESS AND PHONE NO.	REFERRAL DATE

11. LANGUAGE SPOKEN BY APPLICANT	LANGUAGE SPOKEN BY FAMILY / RESPONSIBLE PERSON
☐ English ☐ Spanish ☐ Native American: ☐ Other:	☐ English ☐ Spanish ☐ Native American: ☐ Other:

12. LEGAL GUARDIANS *(Attach copy of court order if applicable)*

NAME *(Last, First, M.I.)*	RELATIONSHIP	HOME MAILING ADDRESS *(No., Street, City, State, ZIP)* AND PHONE NO.

13. BIRTH PARENTS *(If different than above)*

MOTHER'S NAME *(Last, First, M.I.)* ☐ Absent	HOME MAILING ADDRESS *(No., Street, City, State, ZIP)* AND PHONE NO.	EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)* AND PHONE NO.

FATHER'S NAME *(Last, First, M.I.)* ☐ Absent	HOME MAILING ADDRESS *(No., Street, City, State, ZIP)* AND PHONE NO.	EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)* AND PHONE NO.

14. CHILDREN / OTHER ADULTS IN THE HOME

NAME *(Last, First)*	RELATIONSHIP	BIRTH DATE	NAME *(Last, First)*	RELATIONSHIP	BIRTH DATE

15. EMERGENCY CONTACT

NAME *(Last, First, M.I.)*	RELATIONSHIP	HOME MAILING ADDRESS *(No., Street, City, State, ZIP)* AND PHONE NO.	BUSINESS PHONE NO.

16. DIRECTIONS TO HOME

See EOE/ADA disclosure on page 4. • Disponible en español.

17. BENEFITS / EVALUATIONS / SOCIAL SERVICES OF APPLICANT *(Complete / check all that apply)*

SERVICE	MONTHLY AMOUNT	CURR. REC.	WILL APPLY	HAS APPLIED	EFFECTIVE DATE	PAYEE'S NAME	COMMENTS
Earned							
SSDI/SSA							
SSI							
VA							
RR							
SPP *(Supplemental Payments Program)*							
CRS *(Children's Rehab. Services)*							
Pilot Parents							
AZ School for Deaf and Blind							
Behavioral Health							
Other							
TOTAL PER MONTH							

18. MEDICAL COVERAGE *(Third party liability)*

TYPE OF COVERAGE	NAME OF PLAN	POLICY HOLDER'S NAME	ADDRESS AND PHONE NO. OF INS. CO. *(No., Street, City, State, ZIP)*	ID OR GROUP NO. AND POLICY NO.	EFFECTIVE DATE
AHCCCS					
ALTCS					
CMDP					
TriCare					
Medicare A					
Medicare B					
Medicare D					
IHS					
**Private					

If **Private is marked, specify by checking all boxes that apply.

☐ HMO ☐ PPO ☐ Standard ☐ Hospital ☐ RX ☐ Out-patient ☐ ER ☐ Dental
☐ Other:

19. PRIMARY CARE PHYSICIAN'S NAME, ADDRESS *(No., Street, City, State, ZIP)* AND PHONE NO.

20. CURRENT / PAST MEDICAL CONCERNS *(Allergies, Hepatitis B, etc.)*

☐ Yes ☐ No Are immunizations current?

21. HOSPITALIZATIONS AND / OR MAJOR ACCIDENTS

WHERE	WHEN	OUTCOME

☐ Yes ☐ No Were accident claims or lawsuits filed?

22. LIST ALL EDUCATIONAL / PROGRAM / JOB HISTORY, PAST AND PRESENT *(Most recent first)*

NAME AND ADDRESS *(No., Street, City, State, ZIP)*	TYPE OF SCHOOL/PROGRAM/JOB	DATE(S)

23. LIST PROFESSIONALS CONTACTED, PAST AND PRESENT *(Doctors, psychologists, therapists, etc.)*

NAME AND ADDRESS *(No., Street, City, State, ZIP)*	PURPOSE OF CONTACT/VISIT	DATE(S)

24. INDIVIDUAL / FAMILY NEEDS AND CONCERNS

SOCIAL / EMOTIONAL (i.e., peer interaction, appropriate behavior) DO YOU HAVE ANY CONCERNS?

COMMUNICATION / LANGUAGE *(Verbal and non-verbal)* DO YOU HAVE ANY CONCERNS?

RECEPTIVE *(i.e., responds to noise, voice, vocalizes sounds, responds to name / commands, comprehension):*

EXPRESSIVE *(i.e., vocalizes other than crying, laughs, vocalizes consonants/vowels, imitates sounds / words, uses jargon speech, says words, combines words, names pictures, uses short sentences):*

HAS THERE BEEN SPECIAL DIFFICULTY ACHIEVING ANY OF THESE SKILLS *(eating, movement, social / emotional, communication)*

DO YOU HAVE ANY OTHER CONCERNS REGARDING DEVELOPMENT?

HAS THE APPLICANT HAD ANY CHILDHOOD / OTHER DISEASES? IF YES, PLEASE EXPLAIN.

HAS THE APPLICANT HAD CONVULSIONS OR SEIZURES? IF YES, PLEASE EXPLAIN

CURRENT MEDICATIONS AND PURPOSE

25. NEEDS AND SERVICES IDENTIFIED BY INDIVIDUAL AND / OR FAMILY *(Also include medical supplies, adaptive equipment, HCBS, etc.)*

IF ELIGIBLE:

☐ I would like the opportunity to choose my own support coordinator, if possible

☐ Please assign my support coordinator

COMPLETED BY	DATE

DDD INTAKE WORKER'S NAME

Print